HIEPI Business & Technical Operations Workgroup Meeting

Meeting Owners	Bill Baggeroer (WG Lead) Tim Andrews (WG Facilitator)
Minutes Authors	Diana Quaynor (WG Business Analyst)
Version	1

Date	7/12/10
Time	9 a.m. – 1 p.m. / ET
Location	(877) 449-6558

AGENDA

Topic "Casting the Net Widely"	Led By	Start	End
OPENING REMARKS – "Considering alternatives & narrowing options" phase	Bill/Tim	9:00 AM	9:10 AM
Consensus & decision-making: • Discussion of transaction mapping to HIE building blocks • Discussion of prioritization • Review of HIE Building Blocks and Business/Technical operations approaches	Tim	9:20 AM	12:45 PM
WRAP UP & next steps • Worksheets	Tim/Bill	12:45 PM	1:00 PM

ATTENDEES

Name	In Attendance (Y or N)	Name	In Attendance (Y or N)
Bill Baggeroer (NH Lead)	Y	Mary Hunt, PA-C, MHS	Y
Carol Roosa	Y	Patricia Witthaus	N
David Briden	Y	Peter Malloy	Y
Diana Quaynor (BA)	Y	Sandy Pardus	Y
Doris Lotz	N	Scott Maclean	N
Fred Kelsey	Y	Shawn Tester	N
Heidi Johnson	N	Theresa Pare-Curtis	N
Hillary St Pierre	N	Tim Andrews (Facilitator)	Y
Kerri Coons	Y	Trinidad Tellez	N
Lorraine Nichols	N	Wendy Angelo, MD	Y
Marcella Bobinsky	Y		
Mary Beth Eldredge	Y		
Mary Brunette, MD	N		

GUESTS

Name	In Attendance (Y or N)
Mark Belanger (PM)	Y
Micky Tripathi (Program Lead)	(phone)

* Via telephone

MEETING HANDOUTS

1. <<HIEPI Summit 2 Presentation 07-12-10.pdf>>

MEETING SUMMARY

Item

1. OPENING REMARKS – "Considering alternatives & narrowing options" phase.
    a. Tim gave a welcome.
    b. There was a discussion on the ONC PIN (*Program Information Notice) from ONC.*
    c. Tomorrow the Final Rule is to be released at 10AM at HHS.
    d. Approach: first we "cast a wide net" and opened up to consider all options. Now we are at the narrowing down phase.
    e. Reminder: we have to address technical components though we don't actually have to build HIE components
    f. We have to translate requirements into operational building blocks,
    g. Program Information Notice
        i. It is recommended that everyone read it.
        ii. Highlights that affect us:
            1. Clear emphasis on e-prescribing, labs
            2. Public Health and Administrative transactions can be addressed in next iteration (post 2011).
            3. Every provider that is eligible for MU needs 1 option for HIE to qualify for MU. The caveat is if provider doesn't have EHR. If they do not have a certified EHR it means they are not eligible. The REC and other programs would try to get them a certified EHR technology.
            4. There is a second layer.
                a. There is more detail regarding Environmental Scan regarding prescriptions, labs; kept up to date over time.
            5. There is also more detail regarding the HIT coordinator role.
            6. Medicaid must be part of the governance process.
    h. Policy suggestion – you don't necessarily have to buy things and you can set a policy requiring certain things, e.g. requiring electronic lab orders. This is a tall order and difficult to do, but you can let the labs take the interface burden.
    i. There was lots of discussion on sustainability, discouraging mandating participation as part of the business revenue model. More focus is paid to cost estimates, timing and how costs will be addressed.

        Q: Is PIN available?
        A: Yes, on Google Sites
        Q: Clarification on e-Prescribing.
        A: We need to offer 1 solution for prescribing gaps. Require gap-filling; possibly require pharmacies to connect.
        Q: What is summary exchange?
        A: The exchange of key summary information. Essentially, HL7; specifically HITSP's C32 document.
        Q: What is key clinical information? Is it the same as CCD, CCR?
        A: Yes, but there will be more clarity with the Final Rule being released tomorrow and there will be clarity on the "all or nothing" approach to MU, as well as clarity on what needs to be in the summary record. Standards rule could change things too.
    j. We reviewed the schedule. We are halfway through the process and now we need to focus on closure and putting information on paper. There is an emphasis on getting to consensus today.
    k. We reviewed where we have been so far.
    l. The facilitator summarized a conversation of Representative Rosenwald's conversation. There are opt-out complexities. Additionally, the Audit requirement clashes with secure routing. There is no intention for the law to add new process to things that are done already today through another channel. We can assume we can push that. The audit requirement is only for tracking.

        Q: Does opt-out only apply to HIE or all exchange?
        A: Don't know.
        Q: Does this occur now?
        A: It is not needed for areas where consent does not apply today.
        Comment: Our consent is broad. The problem we have is that we don't want this going to government (CIA or Homeland Security)
        Comment: Hitchcock and Concord have consent processes defined in their workflow.
        Comment: There is a concern with lack of community engagement in this conversation – Not a lot of information out there focused on the patient. Recommendation is to engage the public.
        Comment: Patient perception is that we should be engaging the public right now or asap. There exists a lot of fear when sharing of records is discussed, mostly due to lack of understanding by the public)
        Comment: There is always a trade-off between perceived privacy problems and function.

Comment: Recommendation is to engage key medical reporters.

m. We reviewed new building blocks (slide 8) showing levels of secure routing and their applicable laws in NH today.
n. We reviewed updates and additions of use cases.

2. Consensus & Decision-Making
    a. Review of strawman prioritization (slide 15)
        i. Phase 1: Secure routing to providers
            1. The Finance WG provided some information – just over $1M per year to operate with a focus on the minimal operation. There is also a need to match this amount. There are not many stakeholders left to fund remaining years.
            2. Legality puts another limitation on phase 1.

                Comment: We need a "1a" list of things that could be done, but are currently outside of law presently.

                Comment: We need marketplace information to verify demand.

                a. Medicaid is a big customer that has reporting requirements and have real demand.
                b. Medicaid funding is more robust.
                c. Public health also has resources; however, coordination is non-trivial.
                d. There is no law against systems sending information; just a designated HIE cannot send information.

                Comment: ACOs (Accountable Care Organizations) focus on payment reform. They may provide answers in the future.
        ii. Phase 2: Some of these are not legal and others are just more difficult. Going to other care settings require infrastructure.
        iii. Lab ordering is high in demand. It should be pushed to Phase 1 because hospitals will pay for it.
            1. Q: What about PCPs? They are the ones that have to meet MU.
            2. A: If you don't use a hospital lab, you can save your patients a lot of money. ACOs will put pressure on this point.
            3. Q: Can we review the Use Case spreadsheet?
            4. Facilitator showed the Use Case prioritization spreadsheet.
            5. Q: Is there public health incentive to coordinate with statewide HIE?
            6. A: No, not from the public health or CDC side – it's required by ONC so one side of federal government requires it, but the other side doesn't even mention it. There's lack of coordination at the federal level.
            Comment: stay away from "Community Record" vernacular in New Hampshire.
                a. They already have a community record in Concord and Exeter
                b. Can we use "community record function" instead?
    b. Translation of Requirements to Reality (slide 21 onward)
        i. Secure routing among providers
            1. There was a review of base functionality.
            2. In New Hampshire, it looks mainly like connecting hospital systems and connecting those that are left out. We will need to:
                a. Bring systems up to a base level of functionality.
                b. Connect across systems.
                c. Deal with those outside of the system
                    i. HAS catchment area is done geographically or by public health regions.
                    ii. This is a guaranteed issue if the provider chooses where they connect. Use requirement to hospitals that they have to take the provider on. This requires subsidy to make this affordable.
                    iii. Stand up the nodes to connect.
                d. Use existing Public Health regions and budgets as public health has designated regions of the state for their program activities and uses these regions when determining public health budgets -- there's a question of how to connect those not connected already through a hospital or other system. Suggestion was to use public health regions to organize them geographically.
                e. Stage based on broadband connectivity for EHR penetration.

                    Q: Are there other requirements outside of use cases, such as EHR-lite?

A: Yes, there are non-functional requirements like reporting, auditing, etc. EHR-lite should be a use case if we decide to do it.
Comment: Asked if EHR-lite would be wanted in the state as non-functional feature. We are going to focus on the bottom layer: Core Infrastructure (secure routing among providers). We have a laundry list of things to cover:

3. AUTHENTICATION & SECURE TRANSPORT: Need addressing scheme. Need to develop a universal provider addressing scheme – we need to know how to address providers independent of their internal scheme. Then address needs to be translated into a delivery system.
4. AUDIT & LOGGING is a legal requirement – we need to specify what would happen if audit request is made. Ideally you want a uniform transport.

Comment: It is assumed that listed in the components is the RLS.
Response: Secure routing among providers is not where RLS is because you know the recipient. The RLS is with the MPI/RLS in the merged medical record on the top level.
Q: If it's a trauma, can a mass message be sent to neighbouring facilities?
A: Break the glass is not supported by this infrastructure. Emergency response is not supported by this direct infrastructure. You can have a more rigorous policy to get authenticate,
Comment: Are we making the assumption that all these hospitals have broadband?
Response: Yes, unless you have a different style of system, the market availability is zero without broadband. For clarification, sending an email to someone is not a problem, but if they want to install a system, with a server and everything, it needs to be certified for MU and wouldn't work very well without broadband. NHIN direct is premised on secure email. (NHIN Direct is trying to get outliers). Just getting email will not qualify you for MU. It needs to be a marketable, certifiable system.
Comment: What's the format that's being supported by routing?
Response: Routing is independent of the package. We can route unstructured documents, but we can also route structured documents, which is the value add (see slide 16).
Comment: Most internal systems don't have a problem list required by meaningful use, but outpatient systems do; however, but they often can't talk to each other. Therefore, the state-wide HIE would be quite valuable as an easier way to connect these internal systems)
Comment: The Technical Infrastructure WG discussed whether to define what you are passing CCD/CCR or other. Flexibility vs. Structure.
Response: you should support both structured & unstructured document. If the question is who has the burden to translate the document to CCD/CCR, then that's a different point. In the IFR they have both (CCD/CCR), but our preference is CCD. Debate is who does the work? Is it more efficient to say we'll specify the CCD and you'll have to do the work to get it done, or get a vendor to standardize? Right now vendors treat the document as a sort of PDF that is not directed to specific fields.

a. Facilitator showed the difference between HIE, HIO and nodes on a flipchart.

Comment: It's a policy issue to determine who can join the HIE. Where does this decision get made?
Response: In governance & legal.
Comment: We can look at VITL as an employer. VITL was set up to tax the payers.
Response: This is just a fax-type messaging. Let's look at the parallel manual entry process; it's the same, except we've inserted an electronic messaging and storage process. Our proposal still requires manual intervention, except instead of a fax or piece of paper, you now have it electronically. Regardless of whether it's a structured document or not, there will be somebody who will have to look at the document before integrating it into the patient's ehr. Part of the dialogue is to try to do what we have to do to create the least disruption as possible, with the most value as possible (with as little disruption of workflow as possible). It is very important to wrestle the EMR vendors as much as possible and get them to integrate the documents properly

Comment: There is a multi-state (7 states) HIE group that is looking at defining standards to make this easier and looking at vendor leverage.
Response: The real question is how much can we afford? Patient matching has issues. Doctors have existing relationships, but patient to doc, doc to patient is more difficult. Patient engagement and patient access to information is a big deal, but it's very complex.

c. HIE and Infrastructure Building Blocks: Technical Infrastructure Details (slide 25)
    i. NODES: How many nodes are there going to be? There are 28 hospitals, but there may be other independent nodes to connect to.
        a. For HIPAA requirements, if you translate PHI, it has to be encrypted. The most effective way today is to use public keys because there are 2 keys involved (based on 1-way math), e.g. I can take your public key & use it to encrypt my message securely, but I cannot decrypt it. On the other side there is a private key that is never published. You can't undo it once you scramble it. When bits are mentioned they refer to the length of the keys which determine the strength of the encryption: a 128-bit encryption is the length of the key.
        b. Double authentication from each node. This is called mutual authentication –nodes authenticate each other before transmitting messages creating a very secure channel.
        c. Certificates and encryption are only required at the node level, so providers don't need their own certificates. On the provider level, it's a big deal because it would have exploded the number of certificates. The DEA said the prescriber doesn't have to have a digital certificate, but the prescription has to be digitally signed.
        d. There is an argument for doing this (issuing and tracking certificates) at the state level, but there is also an argument for having it at the highest level (national or international). Privacy & security of information is paramount; it's worth every effort.

Comment: Policy integration of state HIE is where there's real value.

d. HIE and Infrastructure Building Blocks: Policy Details (slide 26)
    i. Policy details are going to be specified by other people.
e. Considerations for Business Operations (slide 27) This covers:
    i. Program/project management: Who manages input from stakeholders? Individual projects like provider directory has to be managed too.
    ii. Organizational certification/compliance monitoring– once you have a network, how do people qualify to get onto it?
    iii. Rollout planning/management – there's a REC project going on to get people up, but it will be phased & planned.
    iv. Coordination with other programs – there's a requirement to have the HIE coordinated with other programs.
    v. Vendor procurement strategies/vendor management– technical & legal group will be involved in addressing the contractual needs for this. Somebody has to develop the RFP, but it will be sorted out in the Governance WG.

Q: Have we included contractual agreements with vendors & members?
A: In bullet 2 (organizational certification/compliance monitoring), it's included there.

f. Considerations for Technical Operations (slide 28)
    i. Certificate authority and management – this involves identity management at the node level as well as PKI mechanics—for issuing, tracking & revoking.
    ii. Micro data center - If we wanted to add value we have to make sure it's reliable, even if the infrastructure is minimal.
        1. Help desk, system monitoring & incident management are essential to keeping things running smoothly
    iii. Maintenance – there is some level of maintenance and upgrade needed.

Q: shouldn't we be looking at metrics to determine what the HIE will impact?
A: Right now, it's a digitally homeless item; until you know what systems you have, you can't determine what measures you have to track; however, once you know, you do have to define metrics and run them. At the beginning it will be process measures (e. g. how many electronic prescriptions transmitted), but ultimately it will measure value of care for better outcomes. This will get some attention starting 3 months for now.
Q: Is the biz & technical ops considerations for phase 1 only?
A: Yes, to start.

3. Wrap Up/Next Steps:
    a. Main take-aways:
        - Market availability ranking was confusing in the grid - 1 meant easily available but this didn't necessarily translate into 'green' or good. Ranking seems inverted - all the 1's are in phase 3 - should we invert?

        - Lab ordering was suggested as a service that hospitals would pay for. Theory was that if we were going to route results we should look at vendors that could also take orders as part of statewide HIE infrastructure and then propose that hospitals pay the extra costs.

        - PowerPoint slides don't make it clear that when we talk about secure routing we are talking about routing that will support MU - using CCD/CCR as per requirements. We should make this explicit as this is high value. If we also provide translation to/from CCD/CCR even the sophisticated hospitals thought this would be worthwhile and worth paying for. They do secure messaging but using proprietary formats.

        - Community record was considered by some a trigger phrase that would scare many patients. They felt it implied a repository and could then be spied on by CIA or someone.

        - Harmonizing policy - consent and more - across state lines is very high value activity for this entity – especially for DHMC - probably an issue for governance and legal//policy

    b. Closure – it's not easy. We have legal & funding constraints. What are the best things we can do right now & how can we make the best decisions. We will make some mistakes by going fast, but we want to be as nimble as we can.
        Q: The ONC PIN announcement came out last week, is someone going through it with a fine tooth comb?
        A: Yes, we already did that at first glance, but we'll be referring to it more as we go along.
        Q: The agenda included worksheets- was that for homework?
        A: We will not be using them so don't worry about them.

ACTION ITEMS (FROM PREVIOUS MEETINGS AND NEW)

Item #	Raised By	Action Item Description / Comment	Assigned To	Due Date	Status/ Remarks
1	Tim	Think about critical and valued use cases for New Hampshire in terms of where we want to prioritize our activities.	All	6/28/10	Ongoing until 7/6
2	Mary Beth	Suggested Collaborative Tools: GoToMeeting and WebEx for T-Cons.	Bill	7/6/10	Agreed GoToMeeting provided.
3	Diana	Clarify/define some key terms, e.g. ER vs. ED, Mental Health vs. Behavioral Health	All	7/26/10	
4	Tim	Need a parallel set of Public Health use cases from the state perspective	All?	7/6/10	Completed
5	WG member	A request to look into providing cc: on messages so that delivery can be to multiple providers.	Tim	7/12/10	
6	WG member	Look into Surescripts fill rate issue	Tim	7/12/10	
7	WG member	Determine whether we can include Home health care/VNA in routing - for discharge example	Tim	7/12/10	

ISSUES IDENTIFIED

Issue #	Raised By	Issue Description	Assigned To	Due Date	Status/Remarks
1		None			

DECISIONS MADE

Decision #	Sponsor	Decision Description	Approved (Y or N)	Comments
1		None		